



2018 QUALIFYING EVENTS

Dependent Eligibility Documents Retirees covering health insurance dependents must provide eligibility documentation. See page 9 for details.



QUALIFYING EVENTS - Changing or Canceling Your Benefits



WHAT IS A QUALIFYING EVENT?

- Marriage
- Having or adopting a child
- Divorce
- Loss of other group health insurance
- Legal guardianship or court order
- Spouse has a different Open Enrollment period

Health Insurance

KEHP is operated as a federally regulated, Section 125 Cafeteria Plan. In exchange for this benefit, there are only three times you can change your benefit elections during the plan year:

- During the enrollment period when you first become eligible for benefits;
- During the annual Enrollment period; or
- If you experience a life event, referred to as a Qualifying Event.

When you have a Qualifying Event

In all cases, any change in your plan option or coverage level must be consistent with the qualifying event. For most events, you must complete a Health Insurance Qualifying Event Form and submit it to your Insurance Coordinator or Human Resource Generalist within 35 calendar days of the event date. If you have a baby or adopt a child, you have 60 calendar days to add the child to your plan. If you are adding additional dependents along with the baby or adopted child, then you have 35 calendar days. You must submit dependent eligibility documentation, such as a marriage certificate or birth certificate, together with your Qualifying Event Form.

Qualifying events are complicated and, at times, difficult to understand. There are restrictions on the types of changes you may make due to federal qualifying event rules. If you do not sign and date the required Forms in a timely manner, you will not be permitted to revise your coverage election until the next Enrollment period.

For additional information and forms for Qualifying Events:

<https://kyret.ky.gov/Members/Insurance/Pages/Qualifying-Events.aspx>



Notice for Hazardous Duty Retirees: When a child turns age 22 and is no longer eligible for the health insurance contribution, this is not a qualifying event to drop the dependent from health insurance coverage. Please contact KRS if you have questions.



If you do not sign and date the required Form in a timely manner, you will not be permitted to revise your coverage election until the next Enrollment period.

1. Qualifying Events

KEHP is provided through a Section 125 plan per the Internal Revenue Code. This allows Employees to pay for their Health Insurance premiums with pre-tax dollars. Section 125 plans are federally regulated, and the guidelines state that if an Employees' Health Insurance or Flexible Spending Account is offered through a Section 125 plan, they cannot make a change to their Health Insurance or Flexible Spending Account options outside of the annual Open Enrollment period, unless they experience a permitted election change (referred to as Qualifying Events).

A. To Enroll in KEHP Outside of the Annual Open Enrollment Period, the Individual:

1. Must Lose Coverage From:

- An employer-sponsored group health plan;
- An individual Health Insurance plan (must lose eligibility – failure to pay premiums is not a loss of eligibility);
- A short-term, limited-duration insurance policy also known as “gap” insurance;
- A student Health Insurance policy; or
- A government coverage (TRICARE, Medicare, Medicaid, KCHIP)

Losing coverage from one of the following does not allow the individual to enroll outside of the annual Open Enrollment period:

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- VA Benefits;
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Must Lose Coverage Due To:

- A maximum benefits level being reached;
- An insurance agency canceling the policy (other than for non-payment);
- Coverage being provided under COBRA and COBRA has expired;

Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage including but not limited to:

- Legal separation, divorce, end of Dependent status, death of an Employee, termination of employment, reduction in hours or employer contributions for coverage were terminated; or
- The plan no longer offers benefits for a group of individuals.

Not Due To:

- Non-payment of insurance premiums – choosing to stop payment of a plan for any reason;
- Non-renewal – choosing to stop renewal of a plan for any reason;
- Cancellation of coverage by policyholder for policyholder or for a Dependent;
- Increase in cost of coverage
- Reduction of contributions or level of benefits.



B. General Guidelines

1. Event Date

The Event date is the date the event occurs. It is not the date the Employee or Dependent is notified of the event. The only exceptions to this are entitlement to:

- Medicare
- Medicaid

In the instances above, the Qualifying Event date can be the date the Employee or Dependent is notified.

2. Signature Date

The Signature Date is the date the Employee's signature is on the applicable documentation. Most Qualifying Events have a signature deadline of 35 calendar days from the Event Date. However, some have a signature deadline of 60 calendar days from the Event Date. It is important to know the deadlines for the Signature Date for all Qualifying Events.

To calculate the number of calendar days, begin counting on the day after the Qualifying Event. Example: If the Employee gets married on March 5, the Employee must sign the applicable forms within 35 calendar days from the event (marriage). Day one would be March 6, and day 35 would be April 9. The Employee's signature must be on the applicable Forms no later than April 9.

Pre-Signing

Applicable forms may not be signed prior to the event date, except for the following:

- Loss of other health coverage;
- Gaining other health coverage;
- Entitlement to Medicare; and
- Spouse's different Open Enrollment period

The timing of the signature date is critical. Employees must complete the Enrollment Forms and sign the applicable Forms before the signature date deadline. The Employee does not need to wait for any supporting documentation to arrive before the Form is signed.

3. Effective Date

The Effective Date is the date the coverage takes effect. Most Effective Dates are the first day of the month following the signature date. Coverage can NEVER be effective prior to the Event Date.

Always consider the following:

- If the Qualifying Event date is the first of the month, the Employee may pre-sign during the previous month.

Example: If "loss of coverage" occurs on April 1, the Employee may sign the applicable documentation during the month of March. The Effective Date of the change will be April 1.

- If the Qualifying Event date is any other day of the month, the Employee may pre-sign during that month only.

Example: If "loss of coverage" occurs on April 18, the Employee may sign the applicable documentation during the month of April. The Effective Date of the change will be May 1. The Employee is not permitted to sign in March since that would make the Effective Date April 1, which is effective prior to the event of April 18.

4. Supporting Documentation

Most all QEs must be validated with supporting documentation, such as, but not limited to marriage certificates, divorce agreements, or letters from employers. Before a Dependent can be added to a health insurance plan, verification documents must be provided. See Dependent Eligibility Chart on page 9.

5. Qualifying Event Charts

The Qualifying Event chart is your guide in knowing what mid-year election changes are permitted under a Section 125 plan, and the documentation that is required.



QUALIFYING EVENTS	CHANGE	DOCUMENTS UNLESS STATED, ALL CASES USE: • Qualifying Event Form
Change In Employee's Legal Marital Status		
Gain Spouse due to: • Marriage	Marriage: <i>ADD: Employee may enroll or increase Coverage Level for newly eligible Spouse and Dependent children. Plan Option change may be made. DROP: Employee may terminate or decrease Employee's or Dependent's coverage ONLY when such coverage becomes effective or is increased under the Spouse's plan. (Gain of Other Coverage). Employee may not drop Health Insurance coverage and choose a Waiver HRA mid-year.</i>	Additional Documents: • Health Insurance • Marriage Certificate • Notification from employer, on employer's letterhead or electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, with coverage Effective Date; or an email from the employer with HR signature block; or a self-service enrollment confirmation that states the employer name, effective date and person(s) covered.
Lose Spouse due to: • Divorce • Legal Separation • Annulment • Death	<i>ADD: May elect coverage for Employee, or Dependents who lose eligibility under Spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment, or death. (Loss of Coverage).</i> <i>DROP: Employee may terminate election ONLY for Spouse. Plan option change may be made.</i>	Additional Documents: • Health Insurance • Divorce Decree/Court Order/Death Certificate • Notification from employer on letterhead or electronically, that includes person(s) covered and coverage termination date; letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or termination letter from governmental agency providing previous coverage.
Change In Number of Employee's Dependents		
Gain dependent due to: • Birth • Adoption • Placement for adoption	<i>ADD: Employee may enroll or increase Coverage Level for self, Spouse and newly eligible Dependent children. Plan option change may be made.</i> <i>DROP: Employee may terminate or decrease Employee's or Dependent's coverage if Employee or Dependent becomes eligible under Spouse's plan.</i>	Additional Documents: • Health Insurance • Birth Certificate/Court Order • Notification from employer, on employer's letterhead or electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, with coverage Effective Date.
Lose dependent due to: • Death (child)	<i>DROP: Employee may drop coverage only for the deceased Dependent. Plan Option change may be made.</i>	Additional Documents: • Health Insurance • Death Certificate

Event causing employee's dependent to cease to satisfy eligibility requirement	<i>DROP: Employee may decrease or terminate election only for affected Dependent. Plan Option change may be made.</i>	
Dependent ceases to satisfy eligibility requirements – Aging out (over 26)	<i>DROP: Employee may decrease or terminate election only for affected Dependent. Plan Option change may be made.</i>	Automatic
Starting employment <i>or other change of employment status by employee, spouse, or dependent that triggers eligibility</i>		
Starting employment by employee (new hire)	<i>ADD: Provided that eligibility was gained for KEHP coverage, Employee may add coverage for Employee, Spouse, or Dependents.</i>	Additional Documents: <ul style="list-style-type: none">• Health Insurance• Employee Self-Service
Starting employment by spouse or dependent	<i>DROP: Employee may terminate or decrease Coverage Level if Employee, Spouse, or Dependent is added to Spouse's or Dependent's plan. Plan Option change may be made.</i>	Additional Documents: <ul style="list-style-type: none">• Health Insurance• Notification from employer, on employer's letterhead or via electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, with coverage Effective Date; or an email from the employer with HR signature block, or a self-serve enrollment confirmation that states the employer name, effective date and person(s) covered.
Termination of employment <i>By employee, spouse, or dependent that causes loss of eligibility (or other change in employment status)</i>		
Termination of employee's employment	<i>DROP: Employee, Spouse, and Dependent(s) coverage terminates.</i>	Additional Documents: <ul style="list-style-type: none">• Health Insurance
Termination of spouse's or dependent's employment or other change in employment status resulting in a loss of eligibility	<i>ADD: Employee may enroll or increase Coverage Level for Employee, Spouse, or Dependents who lose eligibility under Spouse or Dependent employer's plan. (Loss of Coverage). Plan Option change may be made.</i>	Additional Documents: <ul style="list-style-type: none">• Health Insurance• Notification from Employer on letterhead or electronically, that includes person covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.
Clean transfer from one participating employer to another with no break in service	No election changes permitted.	Update Forms on file
Small break transfer 1-10 working days	No election changes permitted.	Update Forms on file

Large break transfer 11 or more working days	<i>Treat as new Employee. The new hire waiting period applies and Employee may make new elections.</i>	Additional Documents: • Health Insurance
Change in coverage under other employer plan		
Other employer plan decreases or ceases coverage	<i>ADD: Employee may enroll or increase election for Employee, Spouse, or Dependents if Employee, Spouse or Dependents have elected or received corresponding decreased coverage under other employer plan.</i>	Additional Documents: • Health Insurance • Proof of change in other employer coverage.
Open enrollment under other employer plan/ different year	<i>Employee may enroll or increase election for Employee, Spouse and Dependent(s). Corresponding changes can be made under employer's plan</i>	Additional Documents: • Health Insurance • Notification from employer on employer's letterhead or electronically, identifying Open Enrollment period and deadline, Effective Date of plan, Persons being added or dropped from the policy
Loss of health coverage		
Loss of eligibility for health coverage sponsored by a governmental or educational institution (Medicaid, KCHIP, Medicare)	<i>ADD: Employee may enroll or increase Coverage Level for Employee, Spouse, or Dependent if Employee, Spouse, or Dependent loses group health coverage sponsored by governmental or educational institution. Prospective change only.</i>	Additional Documents (if applicable): • Medicaid & KCHIP • MET form • Medicare • Notification from Medicare
Loss of eligibility for individual health coverage (marketplace)	<i>ADD: Employee may enroll or increase Coverage Level for Employee, Spouse, or Dependent if Employee, Spouse, or Dependent loses group health coverage sponsored by governmental or educational institution. Prospective change only.</i>	Additional Documents: • Proof of loss of eligibility from Marketplace • Health Insurance
Loss of group health coverage	<i>ADD: Employee may elect coverage for Employee, Spouse, or Dependent who has lost other coverage if: (a) The Employee or Dependent was covered under a group health plan or had Health Insurance coverage at the time coverage was previously offered to the Employee or Dependent.</i>	Additional Documents: • Health Insurance • Notification from employer, on employer's letterhead or via electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, with coverage Effective Date; or an email from the employer with HR signature block, or a self-serve enrollment confirmation which states the employer name, effective date and person(s) covered.

Other		
Special enrollment due to eligibility for state premium assistance subsidy from Medicaid or CHIP	<i>ADD: Employee may elect coverage for Employee or Dependent who has become eligible for premium assistance subsidy from Medicaid or CHIP. Plan Option change may be made.</i>	Additional Documents: <ul style="list-style-type: none"> • Health Insurance
Order requiring coverage for child under employee's plan – signed by a judge	<i>ADD: Employee may change election to provide coverage for the child.</i>	Additional Documents: <ul style="list-style-type: none"> • Health Insurance • Court Order See Dependent Eligibility Chart
Order requiring coverage for a dependent child, due to a new order releasing the employee – signed by a judge	<i>DROP: Employee may change election to terminate coverage for the child.</i>	Additional Documents: <ul style="list-style-type: none"> • Health Insurance • Order signed by a judge
Employee, spouse, or dependent becomes entitled to Medicare or Medicaid	<i>DROP: Employee may elect to cancel or reduce coverage for Employee, Spouse, or Dependent as applicable.</i>	Additional Documents: <ul style="list-style-type: none"> • Health Insurance • Copy of Medicare card (showing Effective Date) or Initial eligibility letter from Medicare Office • Medicaid Eligibility/Termination (MET) Form signed by the Division of Medicaid Services – Cabinet for Health and Family Services
Employee Starts Military Leave (Unpaid) Employee Returns From Military Leave (Unpaid)	<i>Leave: Employee on military leave may either terminate coverage or continue coverage. The Employer will continue to maintain the Participant's benefits on the same terms and conditions as if the Participant were still an active Employee.</i> <i>Return: Reinstate prior elections unless another event has occurred that allows a change.</i>	Additional Documents: <ul style="list-style-type: none"> • Military Issued Orders or supporting documentation of military leave.



Get all your documents, more detailed information, and current news from our website.

<https://kyret.ky.gov/Members/Insurance/Pages/Qualifying-Events.aspx>

Dependent Eligibility Chart

Definition of Eligible Dependent(s)	Documentation
Spouse: A person who is legally married to an Employee or Retiree.	<i>A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040).</i>
Common Law Spouse: A person with whom you have established a common law union in a state which recognizes common law marriage (Kentucky does not recognize common law marriage).	<i>A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage.</i>
Child Age 0 to 25: <ul style="list-style-type: none"> • In the case of a child who has not yet attained his/her 26th birthday, "child" means an individual who is – • A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or • An eligible foster child of the Employee/Retiree (eligible foster child means an individual who is placed with the Employee/Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody), or • An adopted child of the Employee/Retiree (a legally adopted individual of the Employee/Retiree, or an individual who is lawfully placed with the Employee/Retiree for legal adoption by the Employee/Retiree). 	<p>Natural Child: <i>A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree as a parent, or a copy of the footprint certificate from the hospital indicating baby and parent's name, or verification of the birth document from the hospital indicating the names of the baby and parent.</i></p> <p>Step Child: <i>A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree's Spouse as a parent; a legible copy of the marriage certificate showing the names of the Employee/Retiree and the Spouse; and a photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040).</i></p> <p>Legal Guardian, Adoption, or Foster Child(ren): <i>Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.</i></p>
Disabled Dependent: A Dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified in writing by a physician. A Dependent child will be considered totally and permanently disabled if, in the judgment of KEHP's medical Third Party Administrator (Anthem), the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A Dependent child who is not already covered by KEHP at the time of his/her 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in KEHP on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage.	<p><i>Anthem certifies all disabled Dependents based on medical necessity and Member's financial responsibility for the Dependent. Contact the Enrollment Information Branch at 502-564-1205 for more information. Dependents under age 26 will be enrolled by EIB as a disabled Dependent and Anthem will initiate disabled Dependent certification process. Dependent over age 26, EIB receives request from Member based on loss of other insurance coverage and requests Anthem to initiate disabled Dependent certification process.</i></p> 



HAZARDOUS DUTY RETIREES WITH HEALTH INSURANCE DEPENDENTS

You must file a FORM 6256 every year. You need to provide eligibility documentation for your dependent(s).

CHILD: If your dependent child is between the ages of 18 and 22, you will need to complete Form 6256 (page 25). A Birth certificate or other supporting documentation will be required.

SPOUSE: You will need to complete Form 6256 (page 25). A marriage certificate or other supporting documentation will be required.

NOTE: YOU MUST FILL OUT FORM 6256 EVERY YEAR

Hazardous duty retirees **MUST** submit a Form 6256 in order for legal spouse and eligible dependents to receive health insurance contribution. If you fail to submit the Form 6256*, **YOU WILL NOT RECEIVE PREMIUM CONTRIBUTIONS** for your legal spouse or eligible dependents.

*FORM 6256

Designation Of Spouse and/or Dependent Child for Health Insurance Certification of Dependent Eligibility on Page 25

Dependent Eligibility & Verification for Health Insurance For Hazardous Duty Retirees with Health Insurance Dependents

Children Eligible for Coverage and Premium Contributions: For Plan Year 2018, the spouse and each dependent child of retired hazardous members of KERS, CERS, and SPRS, as well as some disabled members, may be eligible to receive an insurance contribution based upon the retired member's service. Pursuant to KRS 16.505(17), "Dependent child" means a child in the womb and a natural or legally adopted child of the member who has neither attained age eighteen (18) nor married or who is an unmarried full-time student who has not attained age twenty-two (22). (See 105 KAR 1:410). Retired members with children who do not meet this definition may be able to cover their children under the KEHP plan, but will not receive a contribution amount toward the coverage of those children.

Establishing Eligibility: To establish your child's eligibility for the hazardous contribution toward health insurance for 2018, you must certify the child's eligibility on a completed Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance. This certification Form must be completed annually to receive the contribution. If you submit the required certification and your child is an eligible "dependent child" pursuant to KRS 16.505(17), the contribution will be made for the applicable plan year. Additionally, you must certify that you will immediately provide KRS written notification when your child no longer qualifies. You will be required to reimburse KRS for premiums paid if you make a false or incorrect certification that a child meets the eligibility requirements or if you fail to immediately notify KRS when a child no longer meets the eligibility requirements.

Children Eligible for Coverage: Pursuant to the Affordable Care Act, children are eligible to remain covered by the parent or guardian's health insurance until the first day of the month following their 26th birthday regardless of marital status. Step-children, foster children, and children for whom you have been named guardian may also remain on the plan until the first day of the month following their 26th birthday (in some cases, disabled dependents can be carried past their 26th birthday).

Note: You may continue to cover Hazardous Duty Dependents between the ages of 22-26 as they are eligible for coverage but not eligible for the Premium Contribution. Retiree will be responsible for the additional cost for coverage.

Spousal Coverage: If your spouse has health insurance under your account, a Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance must be completed and submitted to KRS before the beginning of each plan year, or immediately following a qualifying event, for your spouse to receive the hazardous contribution toward health insurance for that plan year. If you divorce a spouse who is covered by health insurance under your KRS account, you must notify our office promptly. An ex-spouse is not eligible to remain on your plan. You must submit a new health insurance application with your ex-spouse removed (or a signed written statement to completely cancel a plan) to this office as soon as the divorce is final. A copy of the Dissolution of Marriage must be provided to KRS as soon as that is available. Without proper notification and documentation, you will be required to reimburse KRS for premiums paid on behalf of an ex-spouse who is no longer eligible for health insurance under your account.

Dependent Eligibility Chart

SPOUSE - A person who is legally married to an Employee or Retiree.

Documentation - A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040).

COMMON LAW SPOUSE - A person with whom you have established a common law union in a state which recognizes common law marriage (Kentucky does not recognize common law marriage).

Documentation - A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage.

CHILD AGE 0 TO 25 - *In the case of a child who has not yet attained his/her 26th birthday, "child" means an individual who is –*

- A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or
- An eligible foster child of the Employee/Retiree (eligible foster child means an individual who is placed with the Employee/Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody), or
- An adopted child of the Employee/Retiree (a legally adopted individual of the Employee/Retiree, or an individual who is lawfully placed with the Employee/Retiree for legal adoption by the Employee/Retiree).

Documentation -

To add a child: A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree as a parent, or a copy of the footprint certificate from the hospital indicating baby and parent's name, or verification of the birth document from the hospital indicating the names of the baby and parent.

To add a step child: A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree's Spouse as a parent and a legible copy of the marriage certificate showing the names of the Employee/Retiree and the Spouse or a photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040).

To add an adopted child, or Foster Child(ren): Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.

Legal Guardian, Adoption, or Foster Child(ren): Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.

DISABLED DEPENDENT - A Dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified in writing by a physician. A Dependent child will be considered totally and permanently disabled if, in the judgment of KEHP's medical Third Party Administrator (Anthem), the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A Dependent child who is not already covered by KEHP at the time of his/her 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in KEHP on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage.

Documentation - Anthem certifies all disabled Dependents based on medical necessity and Member's financial responsibility for the Dependent. Contact the Enrollment Information Branch (EIB) at 502-564-1205 for more information. Dependents under age 26 will be enrolled by EIB as a disabled Dependent and Anthem will initiate disabled Dependent certification process. Dependent over age 26, EIB receives request from Member based on loss of other insurance coverage and requests Anthem to initiate disabled Dependent certification process.



KEHP Tobacco Use Declaration

KEHP TOBACCO USE DECLARATION

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As part of KEHP's LivingWell wellness program, KEHP offers a monthly discount in premium contribution rates for non-tobacco users. You are eligible for the non-tobacco-user premium contribution rates provided you certify, during the health insurance enrollment process, that you or any other person over the age of 18 to be covered under your plan has not regularly used tobacco within the past six months. "Regularly" means tobacco has been used four or more times per week on average excluding religious or ceremonial uses. "Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the method of use. "KEHP Health Insurance Enrollment Application" refers to any method of enrolling in KEHP health insurance coverage including submitting a paper application, completing and submitting an application online, or enrolling in KEHP health insurance coverage through an online enrollment system.

Whether you complete your KEHP health insurance enrollment online or submit a paper application, you are required to certify that all attestations regarding tobacco use are accurate. By completing the enrollment process, you certify the following:

- 1.** I have truthfully answered all questions in my KEHP Health Insurance Enrollment Application regarding tobacco use by me, my spouse, and my dependents 18 years of age and over. My KEHP Health Insurance Enrollment Application accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
- 2.** I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2018, if I answered "Yes" to any of the questions in the Tobacco Use Declaration section of my KEHP Health Insurance Enrollment Application.
- 3.** I understand that it is my responsibility to notify KEHP of any changes in my tobacco-use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the Plan Year. Notification shall be made by completing a Tobacco Use Change Form.
- 4.** I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the Plan Year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form. Both cross-reference planholders must sign the Tobacco Use Change Form.
- 5.** I understand that if I answered "No" to the questions in the Tobacco Use Declaration section of my KEHP Health Insurance Enrollment Application, and either I or a spouse or dependent covered under my insurance plan become a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco-user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
- 6.** I understand that the Tobacco Use Declaration is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
- 7.** I understand that if I fail to complete the Tobacco Use Declaration truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.
- 8.** The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its LivingWell wellness program. Each KEHP member has at least one opportunity per Plan Year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

KEHP Terms and Conditions

KEHP TERMS AND CONDITIONS

Below are the Terms and Conditions for participation in group life and health insurance coverage administered by the Department of Employee Insurance (DEI).

An Employee/Retiree may affix a signature to a paper copy of the KEHP Health Insurance Enrollment Application, the Group Life Insurance Application, or an electronic version of the applications. By typing your name on an electronic application or by logging in and using your unique KHRIS User ID and enrolling through the Employee Self-Service portal, you are agreeing to conduct enrollment in life and/or health insurance coverage by electronic means, thereby creating a legal and binding contract. By affixing your signature in either manner, you understand and agree that:

A. PLAN YEAR. The 2018 Plan Year begins January 1, 2018, and ends at midnight on December 31, 2018.

B. EFFECTIVE DATE OF ELECTIONS. If you are electing a health plan or enrolling in optional life insurance or a Flexible Spending Account (FSA) during enrollment, the FSA and your health and life insurance will be effective January 1 of the following Plan Year. If you are a new employee or a newly eligible employee electing a health plan or enrolling in optional life insurance or an FSA outside of enrollment, the FSA and your health and life insurance will be effective the first day of the second month after a new employee or newly eligible employee is eligible to enroll. Employees enrolling in life insurance must be actively at work, full time, on the day the employee's insurance is scheduled to begin.

C. PLAN INFORMATION. You have read and understood the 2018 Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) or Medical Benefit Booklets (MBB) and the Summary of Benefits and Coverage (SBC). Life insurance rules and limitations are outlined in the Certificate of Coverage (CoC). All benefits for your eligible dependents and you will be provided in accordance with the rules and limitations in the SPDs, MBBs, BSG, SBCs, and CoC. You will abide by all terms and conditions governing participation, membership, and receipt of services from the plan(s) in which you have enrolled and as set forth in the SPD, MBB, and CoC. In the event of a conflict between the terms of coverage stated in the SPDs, the MBBs, the BSG, the SBCs, and the CoC, the terms of coverage stated in the SPDs or MBBs and CoC will govern.

D. THIRD PARTY ADMINISTRATORS. DEI uses third parties, including Anthem, CVS/caremark, WageWorks, Go365, Vitals, and Nationwide Life Insurance Company to provide certain administrative functions. DEI may communicate with you directly or through these third parties about your insurance coverage, your benefits, or health-related products or services provided by or included in KEHP's health plans or KGLI plans.

E. CROSS-REFERENCE. If your spouse and you elect the cross-reference payment option, you are planholders with family coverage, and upon a loss of eligibility by either spouse, the remaining planholder will default to a parent plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.

F. DEPENDENT ELIGIBILITY. You certify that each enrolled dependent meets KEHP's dependent eligibility requirements as set forth in the SPD and MBB (health) and the CoC (life). DEI may require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in benefits.

G. CHANGING ELECTIONS. The elections indicated by your KEHP Health Insurance Enrollment Application, Group Life Insurance Application, or online enrollment may not be changed or cancelled during the Plan Year without a permitted Qualifying Event.

H. DEDUCTION FROM EARNINGS. When you enroll in an FSA, optional life insurance, and health insurance, you authorize your employer to deduct from your earnings the amount required to cover your employee contribution to the FSA, your employee contribution to health insurance, and your life insurance premium, including any arrears you may owe. Deductions for FSA and the employee contributions to health insurance are made on a pre-tax basis unless you sign a Post-Tax Request Form. Deductions for life insurance premiums are made on a post-tax basis.

I. PRIORITY OF PAYMENTS. Any moneys submitted to DEI that you intend to be used to fund your FSA, pay for your health insurance premium contribution, or pay for your optional life insurance coverage, may first be used to pay other priority debts that may be due and owing, such as taxes and child support.

J. DEPENDENT CARE FSA. If you choose a Dependent Care FSA, you are eligible to seek reimbursement, as authorized by 26 U.S.C. Sections 21 and 129, for dependent care expenses. The Dependent Care FSA may only reimburse eligible dependent care expenses that are incurred during the applicable coverage period.

K. FSA CARRYOVER. Unused amounts of \$50 and up to a maximum of \$500.00 remaining in your Healthcare FSA at the end of the Plan Year will carry over to the next Plan Year and may be used to reimburse you for medical expenses that are incurred during the subsequent Plan Year.

L. WAGeworks HEALTHCARE CARD. WageWorks will administer FSAs and HRAs for the 2018 Plan Year and will issue a WageWorks Healthcare Card to you for the payment of Healthcare FSA and HRA expenses. Your WageWorks Healthcare Card will be suspended if requested claim verification is not sent to WageWorks within ninety (90) days after the card swipe. You agree to follow all rules and guidelines established by the Plan concerning the WageWorks Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck, and offset your Healthcare FSA or HRA if you fail to verify a claim.

M. WAIVING HEALTH INSURANCE COVERAGE. If you elect to waive KEHP health insurance coverage, with or without a Waiver Health Reimbursement Arrangement (HRA), you are doing so voluntarily. If your employer participates in the Waiver HRA program, there are two options available: the Waiver General Purpose HRA and the Waiver Dental/Vision Only HRA. You understand that you will be eligible for the Waiver General Purpose HRA only if you have other group health plan coverage. You further understand that your spouse and eligible dependents, if applicable, cannot be covered under the Waiver General Purpose HRA unless your spouse and dependents also have other group health plan coverage.

KEHP 2018 Benefits Grid

Plan Options			LivingWell CDHP			LivingWell PPO			Standard PPO			Standard CDHP		
			In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum			Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Health Reimbursement Arrangement (HRA)			Single \$500; Family \$1,000	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Single \$250; Family \$500	Single \$250; Family \$500	Single \$250; Family \$500
Annual Deductible*			Single \$1,250 Family \$2,500	Single \$2,500 Family \$5,000	Single \$750 Family \$1,500	Single \$1,500 Family \$3,000	Single \$750 Family \$1,500	Single \$1,500 Family \$3,000	Single \$750 Family \$1,500	Single \$1,500 Family \$3,000	Single \$1,750 Family \$3,500	Single \$3,000 Family \$6,000	Single \$3,000 Family \$6,000	Single \$3,000 Family \$6,000
Annual Medical			Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy
Out-of-pocket Maximum**			Single \$2,750 Family \$5,500	Single \$5,500 Family \$11,000	Single \$2,750 Family \$5,500	Single \$5,500 Family \$11,000	Single \$2,750 Family \$5,500	Single \$5,500 Family \$11,000	Single \$3,750 Family \$7,500	Single \$7,500 Family \$11,000	Single \$3,750 Family \$7,500	Single \$7,500 Family \$11,000	Single \$7,500 Family \$11,000	Single \$7,500 Family \$11,000
Deductibles & Out-of-Pocket Maximums for In-Network and Out-of-Network providers accumulate separately and do not cross apply.														
Co-Insurance			Plan: 85% Member: 15%	Plan: 60% Member: 40%	Plan: 80% Member: 20%	Plan: 60% Member: 40%	Plan: 80% Member: 20%	Plan: 60% Member: 40%	Plan: 70% Member: 30%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%
Doctor's Office Visits			Deductible then 15%	Deductible then 40%	Co-Pay: \$25 PCP; \$45 Specialist	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Physician Care (Inpatient/ Outpatient/Other)			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Diagnostic Tests In Doctor's Office****			Deductible then 15%	Deductible then 40%	Office Visit Co-Pay	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Other Laboratory			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Inpatient Hospital (Semi-Private Room)			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient Hospital/Surgery			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient/ Ambulatory Surgery Center			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Emergency Room (Benefit for emergency medical treatment only)			Deductible then 15%	Deductible then 40%	\$150 Co-Pay then Deductible then 20% Co-Pay waived if admitted.	Deductible then 20%	\$150 Co-Pay then Deductible then 20% Co-Pay waived if admitted.	Deductible then 20%	\$150 Co-Pay then Deductible then 30% Co-Pay waived if admitted.	Deductible then 30%	Deductible then 30%	Deductible then 30%	Deductible then 30%	Deductible then 30%
ER Physician Care			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Ambulance			Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Urgent Care Center			Deductible then 15%	Deductible then 40%	\$50 Co-Pay	Deductible then 40%	\$50 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Routine Well Child			Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 50%	Covered at 100%	Deductible then 50%	Covered at 100%	Deductible then 50%

Plan Options		LivingWell CDHP		LivingWell PPO		Standard PPO		Standard CDHP	
		In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Routine Well Adult		Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 40%	Covered at 100%	Deductible then 50%	Covered at 100%	Deductible then 50%
Mental Health		Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services.							
Autism Services		Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services.							
Allergy Injections		Deductible then 15%	Deductible then 40%	\$15 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Allergy Serum		Deductible then 15%	Deductible then 40%	\$15 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Maternity Care (See SPD for Specifics)		Deductible then 15%	Deductible then 40%	\$25 Co-Pay (office visit pregnancy diagnosed) Delivery Charge: Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Durable Medical Equipment		Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Therapy Services (Per Visit; Physical, Occupational, Speech)		Deductible then 15%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
Chiropractic Care		Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type	Maximum of 30 visits per calendar year, per therapy service type
		Deductible then 15%	Deductible then 40%	\$25 Co-Pay	Deductible then 40%	Deductible then 30%	Deductible then 50%	Deductible then 30%	Deductible then 50%
		Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day	Maximum of 26 visits per calendar year; no more than 1 visit per day

Prescription Drugs — Administered by CVS/Caremark					
Annual Rx Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Single \$2,500 Family \$5,000	Not Applicable	Not Applicable
30-Day Supply*** Tier 1 - Generic Tier 2 - Formulary Brand Tier 3 - Non-Formulary Brand	Deductible then 15%	Deductible then 40%	\$10 \$35 \$55	Not Covered	Not Covered
90-Day Supply (Retail or Mail Order)*** Tier 1 - Generic Tier 2 - Formulary Brand Tier 3 - Non Formulary Brand	Deductible then 15%	Not Applicable	\$20 \$70 \$110	Not Covered	Not Covered

Notes: The boxed areas of the grid are components of each plan most often used by members when choosing a plan option, but are not all inclusive. **You can refer to the Summary of Benefits and Coverage (SBC) for more information.** KEHP has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. However, if an error has occurred, the benefits outlined in the 2018 Summary Plan Descriptions (SPDs) and Medical Benefit Booklets will determine how benefits are paid. Benefits are subject to the terms, conditions, limitations and exclusions set forth in the SPDs.

*Co-pays do **not** accumulate toward the deductible, but they do accumulate toward the applicable out-of-pocket maximum.

For the **LivingWell CDHP and the **Standard CDHP**, all covered expenses apply to the out-of-pocket maximum. For the **LivingWell PPO** and the **Standard PPO plans**, the out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

*** Certain diabetic drugs are subject to reduced co-pays and co-insurance with no deductibles. A 90-day supply of maintenance drugs is subject to lower co-pays and co-insurance. Select preventive/maintenance therapy drugs bypass the deductible on both CDHPs.

**** Claims are processed based on provider billing type which may include separate charges from a lab performing services outside of the doctor's office visit.

KEHP Terms and Conditions

N. WAIVER GENERAL PURPOSE HRA RULES. If you elect a Waiver General Purpose HRA, you declare that you and your spouse and dependents, if applicable, are enrolled in another group health plan that provides minimum value. A “group health plan” refers to coverage provided by an employer, an employer organization, or a union. A “group health plan” does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Veteran’s Benefits, Medicare, or Medicaid. A group health plan that provides “minimum value” means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services. If you elect a Waiver General Purpose HRA and cease to be covered under another group health plan that provides minimum value, you agree to notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated and you may elect a KEHP health insurance plan option or the Waiver Dental/Vision Only HRA. You are permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually at enrollment.

O. HRA CARRYOVER. Unused amounts up to and including \$7,500 remaining in your HRA at the end of the Plan Year may be carried over to the next Plan Year provided you are eligible to elect an HRA. You must elect the same type of HRA in a subsequent Plan Year for the funds to carry over.

P. WAIVER HRA FUNDS AFTER TERMINATION. You may use funds remaining in a Waiver HRA after termination to reimburse you for eligible expenses incurred during the coverage period and prior to termination of the Waiver HRA. Upon termination of employment, the remaining amounts in a Waiver HRA are forfeited, except that you may be reimbursed for any eligible medical expenses incurred prior to the last day of the last pay period worked, provided that you file a claim by March 31 following the close of the Plan Year in which the expense was incurred.

Q. HRA AND FSA EXPENSE REIMBURSEMENT. An HRA and/or Healthcare FSA may only reimburse you for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. The Waiver Dental/Vision Only HRA may only reimburse you for eligible dental and vision expenses. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through your HRA or Healthcare FSA.

R. HRA AND FSA RUN-OUT PERIOD. You have a 90-day run-out period (until March 31) for reimbursement of eligible FSA and HRA expenses incurred during the period of coverage.

S. MINIMUM ESSENTIAL COVERAGE. KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through your employer, you are not eligible for a health insurance premium tax credit if purchasing insurance through the Marketplace. In addition, if you decline coverage for your spouse or dependent, your spouse or dependent will not be eligible for a health insurance premium tax credit if purchasing insurance through the Marketplace.

T. COORDINATION OF KEHP HEALTH PLANS AND MEDICARE COVERAGE. The four KEHP plan options and the Waiver General Purpose HRA must pay primary to Medicare. The Waiver Dental/Vision Only HRA pays secondary to Medicare.

U. TOBACCO USE DECLARATION. You have reviewed the KEHP Tobacco Use Declaration and have truthfully answered all questions in your KEHP Health Insurance Enrollment Application regarding tobacco use by you, your spouse, and your dependents over the age of 18.

V. LIVINGWELL PROMISE. KEHP’s LivingWell wellness program includes the KEHP LivingWell plan options. If you choose one of the KEHP LivingWell plan options, you agree to fulfill a LivingWell Promise. Federal law allows KEHP to reward members who participate in the LivingWell wellness program. For members who choose a LivingWell plan option, the reward includes premium discounts for those who fulfill the LivingWell Promise.

- If you enrolled in a LivingWell plan option for 2017 and you fulfilled your LivingWell Promise, you will receive a monthly premium discount of \$40.00 if you enroll in a LivingWell plan option for 2018. If you enrolled in a LivingWell Plan option for 2017 and you did not fulfill your LivingWell Promise, you will not receive a monthly premium discount of \$40.00 if you enroll in a LivingWell plan option for 2018.
- If you enroll in either the LivingWell CDHP or LivingWell PPO plan options for 2018, you must complete (1) an online Go365 Health Assessment; OR (2) a Biometric Screening between January 1, 2018, through July 1, 2018.
- If you are a new employee and you choose a LivingWell plan option outside of enrollment, you must complete the Health Assessment OR Biometric Screening within 90 days of your coverage effective date.

W. HIPAA. You have rights under HIPAA regarding the protection of your health information. KEHP will comply with the HIPAA Privacy and Security rules, and uses and disclosures of your protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP’s Notice of Privacy Practices available at kehp.ky.gov.

X. FRAUD WARNING. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. You can be held responsible for any fraudulent act that you could have prevented while acting within your duties related to obtaining employer-sponsored health and life insurance, and it may be used to reduce or deny a claim or to terminate your coverage. Information contained in your life insurance benefit elections, if incorrect or misleading, may void the policy effective as of the date of issuance.

Y. ACKNOWLEDGMENT. You have fully read these Terms and Conditions, the KEHP Legal Notices, and the KEHP Tobacco Use Declaration. Your signature on the KEHP Health Insurance Enrollment Application, the Group Life Insurance Application, or your electronic signature used for online enrollment certifies that all information provided during this enrollment opportunity is correct to the best of your knowledge.

Z. EXCEPTIONS MAY APPLY. Exceptions may apply to employees of certain employers participating in KEHP and the Commonwealth’s group life insurance benefits. Exceptions may also apply to KTRS, KRS, LRP, and JRP retirees. Please refer to the participation rules of your employer or retirement system for further information.

KEHP Legal Notices

As a member of the Kentucky Employees' Health Plan (KEHP), you have certain legal rights. Several of those rights are summarized below. Please read these provisions carefully. To find out more information, you may contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534 or visit kehpk.ky.gov.

A. NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA), you have "special enrollment" rights if you have a loss of other coverage or you gain a new dependent. In addition, you may qualify for a special enrollment in KEHP under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

1. HIPAA Special Enrollment Provision - Loss of Other Coverage.

If you decline enrollment for yourself or your eligible dependent(s) (including your spouse) because of other health insurance or group health plan coverage (regardless of whether the coverage was obtained inside or outside of a Marketplace), you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 35 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

2. HIPAA Special Enrollment Provision - New Dependent as a Result of Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent(s). However, you must request enrollment within 35 days after the marriage and within 60 days after birth, adoption, or placement for adoption.

3. CHIPRA Special Enrollment Provision - Premium Assistance Eligibility.

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and you're eligible for health coverage from your employer, Kentucky may have a premium assistance program that can help pay for coverage using funds from the state's Medicaid or CHIP programs. If you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, as well as eligible for health insurance coverage through KEHP, your employer must allow you to enroll in KEHP if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. In addition, you may enroll in KEHP if you or your dependent's Medicaid or CHIP coverage is terminated because of loss of eligibility. An employee must request this special enrollment within 60 days of the loss of coverage. You can find more information and the required CHIP notice at kehpk.ky.gov.

B. WELLNESS PROGRAM DISCLOSURE

LivingWell is KEHP's voluntary wellness program available to all KEHP members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease. Those federal rules include the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health assessment or "HA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). In lieu of completing an HA, you may complete a Biometric Screening, which will include a blood test to check your cholesterol and blood glucose levels. You are not required to complete the HA or to participate in the Biometric Screening or any other medical examination. However, employees who choose to participate in the LivingWell wellness program will receive an incentive in the form of discounted employee premium contributions for your health insurance coverage. Although you are not required to complete the HA or participate in the Biometric Screening, only employees who do so will receive the discounted health insurance premiums.

Additional incentives in the form of gift cards, consumer goods, and other prizes may be available for employees who participate in certain health-related activities such as walking challenges or quitting smoking. In addition, KEHP offers discounted, monthly employee premium contribution rates to non-tobacco users. Each KEHP member has at least one opportunity per Plan Year to qualify for the monthly premium contribution discount. KEHP is committed to helping you achieve your best health. Incentives for participating in KEHP's LivingWell wellness program are available to all employees and KEHP members. If you are unable to participate in any of the health-related activities, or you think you might be unable to meet a standard to earn an incentive under the LivingWell wellness program, you may request a reasonable accommodation or an alternative standard. Contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentive that is right for you in light of your health status. Protections from Disclosure of Medical Information: KEHP is required by law to maintain the privacy and security of your personally identifiable health information. KEHP does not collect or retain personal health or medical information through its LivingWell wellness program; however, KEHP may receive and use aggregate information that does not identify any individual in order to design programs based on health risks identified in the workplace and that are aimed at improving the health of KEHP members. KEHP will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who may receive your personally identifiable health information are persons employed by Go365 (KEHP's wellness administrator) and Anthem (KEHP's third-party medical administrator). This may include nurses in Anthem's disease management program and health coaches in Go365's health coaching program. Disclosure of your personally identifiable health information to these persons is necessary in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records; information stored electronically will be encrypted; and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. In the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you as soon as it is feasible after discovery of the breach.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the LivingWell wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534.

C. THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

COBRA continuation coverage is a continuation of KEHP coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Qualified beneficiaries may elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Each qualified beneficiary has 60 days to choose whether or not to elect COBRA coverage, beginning from the later of the date the election notice is provided, or the date on which the qualified beneficiary would otherwise lose coverage under KEHP due to a qualifying event. The KEHP's third-party COBRA administrator is WageWorks. To learn more about COBRA and your rights under COBRA, please refer to your Summary Plan Description or go to kehpk.ky.gov.

D. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Your plan, as required by WHCRA, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information regarding this coverage, please refer to your Summary Plan Description or go to kehpk.ky.gov.

E. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORNS' ACT)

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96, as applicable) hours. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

F. HIPAA PRIVACY NOTICE

KEHP gathers and collects demographic information about its members such as name, address, and social security numbers. This information is referred to as individually identifiable health information and is protected by HIPAA and related privacy and security regulations. HIPAA requires KEHP to maintain the privacy of your protected health information (PHI) and notify you following a breach of unsecured PHI. In addition, KEHP is required to provide to its members a copy of its Notice of Privacy Practices (NPP) outlining how KEHP may use and disclose your PHI to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. The NPP also informs members about their rights regarding their PHI and how to file a complaint if a member believes their rights have been violated. KEHP's Notice of Privacy Practices and associated forms may be obtained by visiting kehpk.ky.gov.

G. PLAN YEAR 2018 KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE-NOTICE OF CREDITABLE COVERAGE

KEHP has determined that KEHP's prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

H. NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee or retiree, the health benefits available to you represent a significant component of your compensation package. Those benefits also provide important protection for you and your family in the case of illness or injury. KEHP offers a variety of health coverage options, and choosing the option that is right for you and your family is an important decision. To help you make an informed health coverage choice, KEHP publishes a Summary of Benefits and Coverage (SBC). For easier comparison, the SBC summarizes important information about your health coverage options in a standard format. The SBCs are only a summary. You should consult KEHP's Summary Plan Descriptions and/or Medical Benefit Booklet to determine the governing contractual provisions of the coverage. KEHP's SBCs are available on KEHP's website at kehpk.ky.gov. A paper copy is also available, free of charge, by contacting the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534.

I. WAIVER HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If an employer participates in the Waiver Health Reimbursement Arrangement (HRA) program through KEHP, an employee may elect to waive KEHP health insurance coverage and choose a Waiver HRA that is funded by the employer, up to \$2,100 a year. There are two Waiver HRA options: the Waiver General Purpose HRA and the Waiver Dental/Vision ONLY HRA. An employee is eligible for the Waiver General Purpose HRA only if the employee, and the employee's spouse and dependents, if applicable, have other group health plan coverage. An employee that elects a Waiver General Purpose HRA must attest that the employee and, if applicable, the employee's spouse and dependents are enrolled in another group health plan that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services. An employee that elects a Waiver General Purpose HRA and that ceases to be covered under another group health plan that provides minimum value is required to notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated, and the employee may elect a KEHP health insurance plan option or the Waiver Dental/Vision Only HRA. Each employee is permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually during enrollment.

J. MARKETPLACE COVERAGE OPTIONS

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) for employer-offered coverage. In addition, the employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit Healthcare.gov for more information.

NON-HAZARDOUS

Percentage Contribution Premium Calculation Worksheet

Use this Health Insurance Form if:

- You are Non-Hazardous.
- You are a retiree or a beneficiary* receiving benefits.
- Your participation date with KRS was **PRIOR** to July 1, 2003.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2018.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$709.46	\$978.50	\$1,325.64	\$1,479.76	\$818.96
LivingWell PPO	\$729.34	\$1,037.08	\$1,589.10	\$1,767.60	\$876.68
Standard PPO	\$685.38	\$975.90	\$1,497.18	\$1,666.26	\$824.54
Standard CDHP	\$682.80	\$940.64	\$1,450.02	\$1,615.30	\$800.94

** Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KRS. You must contact your spouse's insurance coordinator for information for spouse's portion of the premium.

2. Service Credit

Subtract the following, based upon your months of service.

Applicant's Months of Service	Plan Option	Monthly Premium
240+ months or more	LivingWell CDHP	\$709.46
Contribution based on Plan selected	LivingWell PPO	\$729.34
	Standard PPO	\$685.38
	Standard CDHP	\$682.80
180 - 239 months		\$547.01
120 - 179 months		\$364.67
48 - 119 months		\$182.34
0 - 47 months		\$0

Box 1

Box 2



Your Subtotal before fees
Box 1 subtract Box 2

3. Tobacco Status

Select one, based upon tobacco usage in the past six months. If you are a tobacco user, you will be required to pay the amount in box 3.

Non-tobacco user	+\$0.00
Retiree or beneficiary uses tobacco selecting Single coverage	+\$40.00
Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+\$80.00

Box 3



Box 4



4. LivingWell Promise

Select one, based upon enrollment in LivingWell Plan. If you did not fulfill the LivingWell Promise for plan year 2017, you will be required to pay amount in Box 4 if you select a LivingWell Plan for 2018.

Promise Completed	+\$0.00
Applicant failed to complete Promise	+\$40.00

* KRS does not pay a contribution for coverage on behalf of a beneficiary receiving a monthly retirement benefit. Beneficiaries obtaining coverage should enter "\$0.00" in Box 2. Exception: If you are a spouse beneficiary or a dependent child receiving a monthly benefit under the Fred Capps Memorial Act, contact KRS.

TOTAL

Monthly Premium
Box 1 subtract Box 2
+ Box 3 + Box 4

HAZARDOUS Percentage Contribution Premium Calculation Worksheet

Use this Health Insurance Form if:

- You are Hazardous.
- Combined service of Hazardous and Non-Hazardous.
- You are a retiree or a beneficiary receiving benefits.
- Your participation date with KRS was **PRIOR** to July 1, 2003.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2018.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref*
LivingWell CDHP	\$709.46	\$978.50	\$1,325.64	\$1,479.76	\$818.96
LivingWell PPO	\$729.34	\$1,037.08	\$1,589.10	\$1,767.60	\$876.68
Standard PPO	\$685.38	\$975.90	\$1,497.18	\$1,666.26	\$824.54
Standard CDHP	\$682.80	\$940.64	\$1,450.02	\$1,615.30	\$800.94

* Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KRS. If Cross-Reference option is selected and the retiree has a surplus of contribution to cover the retiree's portion of the premium, it will be applied to the spouse's portion of the premium.

2. Service Credit

Subtract the following, based upon your months of service.

Applicant's Months of Service	Contribution
240+ months	\$729.34
180 - 239 months	\$547.01
120 - 179 months	\$364.67
48 - 119 months	\$182.34
0 - 47 months	\$0

Box 1

Box 2



**PLEASE READ THE
HAZ NOTICE
BEFORE
CONTINUING TO
BOX 3**



**HAZARDOUS DUTY RETIREES
WITH HEALTH INSURANCE
DEPENDENTS**

**Please see page 10 for more
Information Changes and
Contribution Information.**

You must file a FORM 6256 every year. You need to provide eligibility documentation for your dependent(s).

CHILD: If your dependent child is between the ages of 18 and 22, you will need to complete Form 6256 (page 25). A birth certificate or other supporting documentation will be required.

SPOUSE: You will need to complete Form 6256 (page 25). A marriage certificate or other supporting documentation will be required.

Note: If you fail to notify KRS of changes in your dependent's eligibility (child AND spouse), you will **BE REQUIRED TO REPAY** any insurance benefits paid on behalf of the ineligible person. See page 10.

Note: You may continue to cover Hazardous Duty Dependents between the ages of 22-26 as they are eligible for coverage but not eligible for the Premium Contribution. Retiree will be responsible for the additional cost for coverage.

3. Spouse & Dependent Coverage

Select one. If you retired **August 1, 1998 or after**, your additional contribution toward Parent Plus, Couple or Family coverage is based upon hazardous duty service credit only. Apply your service credit to the table below to determine your additional contribution if selecting Parent Plus, Couple or Family coverage. Please enter this value in Box 3.

If you retired **prior to August 1, 1998**, your additional contribution toward Parent Plus, Couple or Family coverage is based upon total service credit. Apply your total service credit to the first table below to determine your additional contribution if selecting Parent Plus, Couple or Family coverage. Please enter this value in Box 3.

Hazardous Service Only ¹	Parent Plus	Couple	Family	Family X-Ref
240+ months	\$307.74	\$859.76	\$1,038.26	\$1,024.02
180 - 239 months	\$230.81	\$644.82	\$778.70	\$768.02
120 - 179 months	\$153.87	\$429.88	\$519.13	\$512.01
48 - 119 months	\$76.94	\$214.94	\$259.57	\$256.01
0 - 47 months	\$0	\$0	\$0	\$0

¹ If you retired prior to August 1, 1998, your additional contribution toward Parent Plus, Couple or Family coverage is based upon total service credit.

Box 3

-

Your Subtotal before fees
Box 1 subtract Box 2 & 3

4. Tobacco Status

Select one, based upon tobacco usage in the past six months. If you are a tobacco user, you will be required to pay the amount in box 3.

Non-tobacco user	+\$0.00
Retiree or beneficiary uses tobacco selecting Single coverage	+\$40.00
Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+\$80.00

Box 4

+

5. LivingWell Promise

Select one, based upon enrollment in LivingWell Plan. If you did not fulfill the LivingWell Promise for plan year 2017, you will be required to pay amount in Box 4 if you select a LivingWell Plan for 2018.

Promise Completed	+\$0.00
Applicant failed to complete Promise	+\$40.00

Box 5

+

Total Monthly Premium
Subtotal (Box 1 - Box 2 - Box 3) + Box 4 + Box 5 = Total

DOLLAR CONTRIBUTION Premium Calculation Worksheet

Use this Health Insurance Form if:

- You are either Hazardous or Non-Hazardous
- You are a retiree or beneficiary* receiving benefits.
- You are Tier 1 with a participation date with KRS **BETWEEN** July 1, 2003 and August 31, 2008. In order to be eligible for health insurance benefits, you must have a minimum of 120 months of service.
- You are Tier 2 with a participation date with KRS on or **AFTER** September 1, 2008. In order to be eligible for health insurance benefits, you must have a minimum of 180 months of service.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2018.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$709.46	\$978.50	\$1,325.64	\$1,479.76	\$818.96
LivingWell PPO	\$729.34	\$1,037.08	\$1,589.10	\$1,767.60	\$876.68
Standard PPO	\$685.38	\$975.90	\$1,497.18	\$1,666.26	\$824.54
Standard CDHP	\$682.80	\$940.64	\$1,450.02	\$1,615.30	\$800.94

** Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KRS. You must contact your spouse's insurance coordinator for information for spouse's portion of the premium.

Box 1

2. Non-Hazardous Service Credit

Subtract the following, based on the calculation of Years of Non-Hazardous Service multiplied by the Health Insurance Dollar Contribution Amount.

Dollar Amount Contribution	X	FULL Years of Non-Hazardous Service	=	BOX 2 TOTAL
\$13.18	X		=	

Calculate the KRS Service Credit Dollar Amount by multiplying the Years of Non-Hazardous Service by the Health Insurance Dollar Contribution Amount.

* KRS does not pay a contribution for coverage on behalf of a beneficiary receiving a monthly retirement benefit. Beneficiaries obtaining coverage should enter "\$0.00" in Box 2. Exception: If you are a spouse beneficiary or a dependent child receiving a monthly benefit under the Fred Capps Memorial Act, contact KRS.

Box 2

3. Hazardous Service Credit

Subtract the following, based on the calculation of Years of Hazardous Service multiplied by the Health Insurance Dollar Contribution Amount.

Dollar Amount Contribution	X	FULL Years of Hazardous Service	=	BOX 3 TOTAL
\$19.77	X		=	

Calculate the KRS Service Credit Dollar Amount by multiplying the Years of Service by the Health Insurance Dollar Contribution Amount, using the appropriate Hazardous and Nonhazardous service credit.

Box 3

Your Subtotal before fees

Box 1 subtract Box 2 and/or subtract Box 3

4. Tobacco Status

Select one, based upon tobacco usage in the past six months. If you are a tobacco user, you will be required to pay the amount in Box 3.

<input type="checkbox"/>	Non-tobacco user	+\$0.00
<input type="checkbox"/>	Retiree or beneficiary uses tobacco selecting Single coverage	+\$40.00
<input type="checkbox"/>	Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+\$80.00

Box 4



5. LivingWell Promise

Select one, based upon enrollment in LivingWell Plan. If you did not fulfill the LivingWell Promise for plan year 2017, you will be required to pay amount in Box 4 if you select a LivingWell Plan for 2018.

<input type="checkbox"/>	Promise Completed	+\$0.00
<input type="checkbox"/>	Applicant failed to complete Promise	+\$40.00

Box 5



Total Monthly Premium
Subtotal (Box 1 - Box 2 - Box 3) + Box 4 + Box 5 = Total

For service in a Non-Hazardous position, you will receive a monthly dollar contribution of \$13.18 for each year of service per month. The Dollar Contribution will increase by 1.5% on July 1st.

EXAMPLE: If you began participating September 1, 2003 in a Non-Hazardous position, and retired effective October 1, 2013, you would receive \$131.80 per month towards health insurance premiums.

For service in a Hazardous position, you will receive a monthly contribution of \$19.77 for each year of service per month. The Dollar Contribution will increase by 1.5% on July 1st.

EXAMPLE: If you began participating September 1, 2003 in a Hazardous position, and retired effective October 1, 2013 you would receive \$197.70 per month towards health insurance premiums.

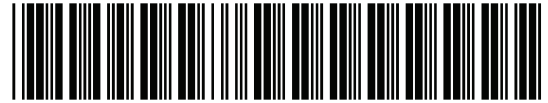
If you have Hazardous and Non-Hazardous service, you will receive contribution based on the amount of full years of service for each.

EXAMPLE: If you began participating September 1, 2003 in a Non-Hazardous position until September 30, 2008 (5 years x \$13.18 = \$65.90), and then began participating October 1, 2008 in a Hazardous position, and retired effective November 1, 2013 (5 years x \$19.77 = \$98.85), you will receive \$164.75 per month towards health insurance premiums (\$65.90 + \$98.85 = \$164.75).

If you have a partial year of Hazardous service and a partial year of Non-Hazardous service, they can be combined to equal a full year and you will receive 1 year of Non-Hazardous service.

EXAMPLE: If you have 9 years and 6 months of Non-Hazardous service and 6 months of Hazardous service, your insurance contribution will be based on 10 years of Non-Hazardous service. You will receive \$131.80 per month towards health insurance premiums.

If you are receiving a monthly retirement benefit that qualifies you to receive a Health Insurance Percentage contribution and also receiving a monthly retirement benefit that qualifies you to receive a Health Insurance Dollar contribution, please contact the Retirement office for help calculating your cost.



Print Form

Form 6200
Revised 10/2017

2018 RETIREE HEALTH INSURANCE QUALIFYING EVENT FORM

Section 1: To Be Completed by Insurance Coordinator									
KHRIS Personnel Number		Hazardous Duty <input type="checkbox"/>		Date of Retirement		Qualifying Event Date		Coverage Effective Date	
<input type="checkbox"/> KRS 80000 10006416		<input type="checkbox"/> TRS 85000 10006418		<input type="checkbox"/> KCTCRS 81000 10006417		<input type="checkbox"/> JRP 86000 10006419		<input type="checkbox"/> LRP 87000 10006420	
KRS Only:		<input type="checkbox"/> KRS-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KRS-SPRS			
Deletion of Dependent					Addition of Dependent				
<input type="checkbox"/> Divorce		<input type="checkbox"/> Gaining Other Coverage			<input type="checkbox"/> Marriage		<input type="checkbox"/> Loss of Other Coverage		
<input type="checkbox"/> Death		<input type="checkbox"/> Gaining Medicare/Medicaid			<input type="checkbox"/> Birth/Adoption		<input type="checkbox"/> Loss of KCHIP/Medicaid		
<input type="checkbox"/> Loss of Eligibility		<input type="checkbox"/> Other _____			<input type="checkbox"/> Guardianship/Court Order		<input type="checkbox"/> Re-establishing Eligibility		
					<input type="checkbox"/> Special Enrollment				
Section 2: Demographic Information									
Retiree's SSN		Retiree's Name (Last, First, MI)				Retiree's Date of Birth			
Applicant's SSN		Applicant's Name (Last, First, MI)				Applicant's Date of Birth			
Street Address				Primary Phone #			Secondary Phone #		
City, State, ZIP			County		Home Email Address				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female					Married: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Section 3: Spouse/Dependent Information - Skip to Section 5 if electing single coverage.									
Spouse's SSN		Spouse's Name (Last, First, MI)			Date of Birth (mm/dd/yyyy)			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Is Spouse Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> I wish to utilize the Cross-reference payment option (two KEHP members, married with children - no LRP or JRP).									
KRS Only:		<input type="checkbox"/> KRS-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KRS-SPRS			
Spouse's Date of Hire/Retirement			Spouse's Organizational Unit #			Spouse's Company #			
Spouse Home Email Address					Spouse Work Email Address				
Section 4: Dependent Information									
(must include dependent verification documents)				Are any dependents Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, who?		
Child #1 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered		<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled		Date of Birth	
								<input type="checkbox"/> Male <input type="checkbox"/> Female	
								<input type="checkbox"/> Tobacco User	
Child #2 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered		<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled		Date of Birth	
								<input type="checkbox"/> Male <input type="checkbox"/> Female	
								<input type="checkbox"/> Tobacco User	

For additional application, please visit <https://kyret.ky.gov/Publications/Forms/Pages/Insurance-Forms.aspx>

Retiree's SSN:

Applicant's SSN:

Child #3 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Tobacco User
Child #4 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Tobacco User

Section 5: TOBACCO USE DECLARATION Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at kehp.ky.gov. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

Planholder: Within the past 6 months, have you used tobacco regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	---

Section 6: Coverage Level

<input type="checkbox"/> Single (self only)	<input type="checkbox"/> Parent Plus (self and child(ren))	<input type="checkbox"/> Couple (self and spouse)	<input type="checkbox"/> Family (self, spouse and child(ren))
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Section 7: Plan Options

<input type="checkbox"/> LivingWell CDHP	<input type="checkbox"/> Standard CDHP
<input type="checkbox"/> LivingWell PPO	<input type="checkbox"/> Default Standard PPO - INSURANCE COORDINATOR USE ONLY
<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Waive Coverage, No HRA - without \$
Reason for Waiving: _____	

Section 8: LivingWell Promise (required for selecting a LivingWell Plan)

I agree to the LivingWell Promise. Electing a LivingWell Promise plan in 2018 means you are required to complete either the ☐ Go365 Health Assessment (HA) or biometric screening from January 1, 2018 through July 1, 2018. Instructions on fulfilling your promise can be found at LivingWell.ky.gov.

Section 9: Signatures - Please submit this application to your Company Insurance Coordinator

By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found in your benefits Selection Guide or online at kehp.ky.gov.

By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

Employee/Retiree Signature	Date
Applicant Signature	Date
Spouse Signature - REQUIRED if electing the cross-reference payment option	Date
IC/HRG Signature	Date
IC/HRG Printed Name	IC/HRG Phone Number
Spouse's IC/HRG Signature - REQUIRED if electing the cross-reference payment option	Date
Spouse's IC/HRG Printed Name	Spouse's IC/HRG Phone Number



Kentucky Retirement Systems

Perimeter Park West • 1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form



Form 6256

Revised 7/2017

Designation of Spouse and/or Dependent Child for Health Insurance

Complete this form if you are a General Assembly Retiree, Hazardous Duty Retiree, Surviving Spouse Beneficiary receiving General Assembly, Hazardous Duty, or duty related benefits under the Fred Capps Memorial Act and electing to cover a spouse and/or dependent child on health insurance.

If you are a recipient as outlined above, you must complete and submit Form 6256 Designation of Spouse and/or Dependent Child for Health Insurance to the Kentucky Retirement Systems (KRS):

- During the annual open enrollment period prior to January 1 each year.
- Upon your health insurance dependent obtaining 18 years of age.

You are required to notify KRS when your health insurance dependent has a change in marital or full-time student status.

Member Information Please provide your Member ID or Social Security Number in the Member ID box below

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Phone Number:	Is this a new address? <input type="radio"/> Yes <input type="radio"/> No		

Spouse Information If different than member.

Spouse Name:	Social Security Number:	Spouse Date of Birth:	
Address:	City:	State:	Zip Code:

Only dependents who meet the definition of a Dependent Child as defined by KRS 16.505(17) are eligible to receive health insurance contributions. KRS 16.505(17) states "Dependent Child" means a child in the womb and a natural or legally adopted child of the member who has neither attained age eighteen (18) nor married or who is an unmarried full-time student who has not attained age twenty-two (22). **Note: Stepchildren and grandchildren must be legally adopted in order to qualify as dependents per this statute.**

Dependent Information (Age 18-22 Dependent Information Only)

Dependent Name:	Social Security Number:	Dependent Date of Birth:	
Address:	City:	State:	Zip Code:

Relationship to Member: ☐ Natural Child ☐ Adopted Child

Is this dependent married or has this dependent been married previously? ☐ Yes ☐ No

Is this dependent age 18 or older? ☐ Yes ☐ No

Is this dependent a full-time student? ☐ Yes ☐ No

Dependent Information (Age 18-22 Dependent Information Only)

Dependent Name:	Social Security Number:	Dependent Date of Birth:	
Address:	City:	State:	Zip Code:

Relationship to Member: ☐ Natural Child ☐ Adopted Child

Is this dependent married or has this dependent been married previously? ☐ Yes ☐ No

Is this dependent age 18 or older? ☐ Yes ☐ No

Is this dependent a full-time student? ☐ Yes ☐ No

Dependent Information (Age 18-22 Dependent Information Only)

Dependent Name:	Social Security Number:	Dependent Date of Birth:	
Address:	City:	State:	Zip Code:

Relationship to Member: ☐ Natural Child ☐ Adopted ChildIs this dependent married or has this dependent been married previously? ☐ Yes ☐ NoIs this dependent age 18 or older? ☐ Yes ☐ NoIs this dependent a full-time student? ☐ Yes ☐ No**Dependent Information (Age 18-22 Dependent Information Only)**

Dependent Name:	Social Security Number:	Dependent Date of Birth:	
Address:	City:	State:	Zip Code:

Relationship to Member: ☐ Natural Child ☐ Adopted ChildIs this dependent married or has this dependent been married previously? ☐ Yes ☐ NoIs this dependent age 18 or older? ☐ Yes ☐ NoIs this dependent a full-time student? ☐ Yes ☐ No**Certification**

I, _____, do hereby certify that the person(s) designated above is the retiree's
(Member Name)

spouse* and/or dependent child** as defined by law as, "a child in the womb and a natural or legally adopted child of the member who has neither attained age eighteen(18) nor married or who is an unmarried full-time student who has not attained age twenty-two (22). I agree that I will immediately provide written notification to Kentucky Retirement Systems as soon as the person(s) designated above no longer qualifies as a spouse* and/or dependent child** as defined by KRS 16.505(17). I understand that Kentucky Retirement Systems shall immediately cease to pay the portion of the health insurance premium made on behalf of the person designated above when that person no longer qualifies as a dependent child** as defined by KRS 16.505(17). I understand and agree that I will be responsible for and shall be required to repay any insurance benefits paid on behalf of the person(s) designated above if the said person is not a dependent child** as defined by KRS 16.505(17) or if I fail to notify Kentucky Retirement Systems when dependent child marries, ceases to be a full-time student, or otherwise ceases to qualify as a dependent child as defined by KRS 16.505(17).

*105 KAR 1:410

**KRS 16.505(17)

I hereby certify that the information provided on this Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance, is true and correct. I further acknowledge that I have full understanding that any person who provides a false statement, report, or representation is subject to penalty or perjury under KRS 523.010 to KRS 523.110.

Member Signature: _____ Date: _____

Who to call FOR HELP

KEHP Enrollment Hotline

**888-581-8834
502-564-6534**

WEBSITE ADDRESSES

Personnel Cabinet – personnel.ky.gov

KEHP - kehpn.ky.gov

mail: kehpn@ky.gov

Wellness - Livingwell.ky.gov

KEHP Vendors' Phone Numbers

Health Insurance Benefits	Anthem	844-402-KEHP (5347)	anthem.com/kehpn
Prescription Benefits	CVS/Caremark	866-601-6934	caremark.com
Wellness Information	Go365	855-478-1623	Go365.com
Shopper Discounts	Vitals SmartShopper	855-869-2133	vitals.com
HRA Benefits	WageWorks	877-430-5519	wageworks.com/kehpn

Retiree Systems' Phone Numbers

LRP and JRP Retiree Questions	Judicial Retirement Plan and Legislators' Retirement Plan	502-564-5310	
KCTCS Retiree Questions	Kentucky Community and Technical College System Retirement	859-256-3100	
KRS Retiree Questions	Kentucky Retirement Systems	800-928-4646 502-696-8800 kyret.ky.gov	kyret.ky.gov
TRS Retiree Questions	Teachers' Retirement System	800-618-1687 502-848-8500 trs.ky.gov	trs.ky.gov

Kentucky Retirement Systems

Call Center

Monday - Friday

8:00am - 4:30pm (EST)

1-502-696-8800 or 1-800-928-4646

Fax (502) 696-8822

Retiree Healthcare FAX (502) 696-8723

**Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601**



OUR OFFICE

Monday - Friday
8:00am - 4:30 pm

(502) 696-8800
or **(800) 928-4646**

Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

krs.mail@kyret.ky.gov
General Questions only
(unsecure)



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Facebook.com/kyretirement

OUR WEBSITE

<https://kyret.ky.gov>

- Member Forms and directions
- News & Updates
- Publications (Recent and Archive)
- Contact Us

SELF SERVICE

MyRetirement.ky.gov

- Update your personal information
- Calculate your benefits
- Get your retirement information

MEMBER EDUCATION

youtube.com/user/KentuckyRetire

- Video Library - How-to Videos
 - How to Retire
 - How to fill out Form 6000
 - How to Calculate Your Benefit
 - ...and more!
- Webinars
(interact and ask questions)



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